Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011756	B. WING		05/01/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
TRINITY H	EALTHCARE INC	819 E 9T ROCHES	H ST STER, IN 46975		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 000	Initial Comments		N 000		
	This was an offsite lic	ensure investigation survey.			
	Survey Date: 5/1/13				
	Facility Number: 0117	756			
	Surveyor: Kelly Hem	melgarn RN			
	•	estigation, the agency was without a current Indiana			
	Quality Review: Joyce May 1, 2013	e Elder, MSN, BSN, BN\			
N 400	410 IAC 17-10-1(a) L	icensure	N 400		
	(1) be opened;(2) be operated;(3) be managed;(4) be maintained; or(5) otherwise conduct				
	agency failed to ensu	t as evidenced by: eview and interview, the re it was operating with a Health Agency license.			
	Findings include:				
	Health dated 12/28/12 [administrator's name your agency's license	na State Department of 2 stated, "Dear]: Our records indicate that to operate a home health f Indiana will expire 4/30/13.			

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _				
		011756	B. WING		05/	01/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
TRINITY H	IEALTHCARE INC	819 E 9TH					
			ER, IN 46975				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
N 400	Continued From page 1		N 400				
	Enclosed is a renewal complete and submit documentation and \$ ensure your application advance of your facility od/30/13 please not incorrectly could cause of your application 2. As of 5/1/13, India Health had not receive application or check in the administrator on 5/1/13 at 11:45 a Healthcare Inc. was suproviding care to appune 4. The administrator 5/1/13 at 12:15 p.m. a received the letter from the alth and the renewal administrator indicates submitting the renewal 410 IAC 17-11-3 Renewal and submitting the renewal 410 IAC 17-11-3 Renewal and submitting the renewal and submitted the	al application for you to with requested 250 license fee to: Please on is complete and arrives in ty's license expiration of the any information sent are a delay in the processing" In a State Department of red a license renewal in the amount of \$250.00. In a state Department of red a license renewal in the amount of \$250.00. In and indicated Trinity still operating and currently roximately 50 patients. In a state Department of red a license renewal in the amount of \$250.00.	N 434				
	license shall be filed visity (60) days prior,	oplication for renewal of with the department at least but not sooner than ninety expiration date of the					
	This RULE is not me Based on document r	at as evidenced by: review and interview, the					

Indiana State Department of Health

STATE FORM 9899 JIL711 If continuation sheet 2 of 3

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
	011756	B. WING		05/01/2013	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TRINITY HEALTHCARE INC	819 E 9TH ROCHEST				
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ON (X5)	
PREFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
N 434 Continued From pag	Continued From page 2				
application for licens	home health agency failed to ensure the renewal application for licensure was filed at least 60 days prior to the expiration of the Indiana home health license. Findings include:				
Findings include:					
Health to the agency "Dear [administrator indicate that your age home health agency expire 4/30/13. End for you to complete documentation and a second documentation and a second documentation and application from Tring 3. The administrato on 5/1/13 at 11:45 a Healthcare Inc. was providing care to application at 12:15 p.m. received the letter from the second documentation and a second documentatio	r was interviewed via phone .m. and indicated Trinity still operating and currently proximately 50 patients. r was interviewed via pone on and indicated he had om Indiana State Department newal application dated still on his desk. The ted he must have overlooked				

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